DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45-4 5/25/13

PRINTED: 04/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445075	A. BUILDING _____ B. WING _____	04/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-MADISON	431 LARKIN SPRING RD MADISON, TN 37115

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F 000	INITIAL COMMENTS A Recertification survey and complaint investigation #'s 30484, 30781, 31052, 31398, were completed on April 11, 2013. No deficiencies were cited related to complaint investigation #'s 30484, 30781, 31052, 31398, under 42 CFR PART 482.13, Requirements for Long Term Care Facilities.	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a homelike environment conducive to dining and resident dignity on four dining observations in the Ruby Room dining area. The findings included: Observation in the Ruby Room dining area on April 8, 2013, at 11:59 a.m., revealed square and round dining tables with table cloths on them. Observation revealed two semi-circle tables in the middle of the room without table cloths. Further observation revealed the Certified Nursing Assistants (CNA) were placing clothing protectors on the residents without first asking the resident if they wished to have a clothing protector. Observation revealed CNA #2 was	F 241	F Tag 241 – Dignity and Respect of Individuality 1) The Director of Nursing/ Staff Development Coordinator 4/25/2013educated and trained 100% of Nursing staff including certified nursing assistant (CAN) #1, CNA #2 and licensed practical nurse (LPN) # 1 assigned to Residents in the Ruby Room regarding promoting care, with an emphasis on addressing residents in a respectful manner, asking if a clothing protector is preferred by the resident, and protecting clothes in a manner that maintains the resident's dignity in recognition of his/her individuality. The education also included training regarding asking residents if they prefer certain condiments before applying to food. All of the other dining rooms were observed to detect non- compliant practices and were corrected at the time of observation. The Assistant Director of Nursing/Designee will conduct observation audit rounds in dining rooms to ensure residents are asked before applying clothing protectors, offering beverages of choice and offering of condiments before providing them, 5	May 10, 2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5/4/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 heard asking "what's...name again" while putting a clothing protector on a resident who was asleep at the table. One resident asked CNA #2, "what is this for?" when CNA #2 placed the clothing protector on the resident and CNA #2 replied "to keep your clothes clean." Continued observation revealed one resident requested apple juice and was told by staff "...only have sweet tea and milk because it is lunch." The resident asked again about apple juice, and one staff member stated "they already told...couldn't have it," the other staff member went and obtained a carton of apple juice and gave it to the resident. Interview with CNA #2 in the Ruby dining area, on April 8, 2013, at 12:05 p.m., confirmed clothing protectors were placed on residents without asking permission, the two semi-circle tables did not have tablecloths, and some of the staff did not check availability of a beverage request before telling the resident requesting there was none. Observation of dining on April 8, 2013, at 11:50 a.m., in the Ruby dining room revealed: CNA #1 placed clothing protectors on eight of twenty- three residents without asking permission. Interview with CNA #1 in the Ruby Dining room, at 1:12 p.m., confirmed the CNA had not asked permission to place clothing protectors on the residents. Further observation of dining on April 8, 2013, at 12:35 p.m., in the Ruby Dining room revealed	F 241	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* times a week x 3 weeks then 3 x a week x 3 weeks and then 1 x a week x 3 weeks and/ or until 100% compliance is met. Staff development coordinator (SDC)/Director of Nursing (DON) Conducted in-service on 4/25/2013 (100% of Nursing staff including C.N.A. #1 and C.N.A. #2) on offering beverages of choice and if not available from the kitchen after checking , then offer choices that are available to them other than what is on their tray to honor beverage requests. All tables in the dining room will be uniform in presentation. Monitored by Director of Nursing / Designee 5 x a week x 3 weeks then 3 x a week x 3 week then 1 x a week x 3 weeks and / or until 100% compliance is met. Semi-circle tables have been replaced. In-service by Housekeeping Supervisor for housekeeping staff completed 5/3/2013 In-service training for LPN#1 by SDC/ Designee on resident dignity during medication administration not administering medications during meals times or in dining areas, completed 4/25/2013. SDC/ Director of Nursing 4/25/2013 (100% nursing staff) In-service on asking resident preferences during meal for condiments and things like syrup for waffles, dignity and	

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F 241	Continued From page 2 Licensed Practical Nurse (LPN) #1 gave medicine to resident # 60 in the dining room. Interview with LPN #1 on April 8, 2013, at 12:40 p.m., confirmed medication was given in the dining room. Observation of breakfast in the Ruby Dining Room, on April 10, 2011, at 7:45 a.m., revealed a CNA placing clothing protectors on five residents without asking them first if they wanted one. Continued observation in the Ruby Dining Room revealed a CNA going from table to table pouring syrup onto the residents' waffles but failed to ask the residents first if they wanted any syrup.	F 241	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* resident choice. 2) The Assistant Director of Nursing/Designee will conduct observation audits in dining rooms asking residents before applying clothing protectors, offering beverages of choice and offering of condiments before providing them 5 times a week x 3 weeks then 3 x a week x 3 weeks and then 1 x a week x 3 weeks and/ or until 100% compliance is met. The Director of Nursing/ Designee will counsel and in-service the staff members identified through this process. 3) The Staff Development Coordinator will conduct education with the nursing staff (4/25/2013) on resident dignity and respect with an emphasis on addressing residents in a respectful manner, timely answering of resident requests and honoring resident choices. The education will also include resident dignity during a medication pass. The Staff Development Coordinator will include information regarding maintaining and/or enhancing patient dignity in the orientation of all new personnel by including resident rights, dignity and the residents right to choose utilizing examples. The Activity Director, or her designee, will interview residents each month at the Resident Council meeting as to whether they are being treated with dignity and respect and will	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to allow the resident the right to chose a bathing schedule for three (#46, #115, #47) of seventeen residents interviewed regarding bathing schedule.	F 242		

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F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to allow the resident the right to chose a bathing schedule for three (#46, #115, #47) of seventeen residents interviewed regarding bathing schedule.	F 242		

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F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to allow the resident the right to chose a bathing schedule for three (#46, #115, #47) of seventeen residents interviewed regarding bathing schedule.	F 242		

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F 242	Continued From page 3 The findings included: Resident #46 was admitted to the facility on March 11, 2010, with diagnoses including Parkinson's Disease, Diabetes, Bowel and Bladder Incontinence, Hyperlipidemia, and history of Cerebral Vascular Disease (CVA). Medical record review of the quarterly Minimum Data Set (MDS) dated February 13, 2013, revealed the resident was cognitively intact for daily decision making; required extensive assistance for personal hygiene, and required one person physical assistance for bathing. Medical record review of the annual MDS dated November 22, 2012, revealed it was "very important" for resident #46 to have choice in bathing. Medical record review of the Care Plan dated March 12, 2013, revealed, "...resident is to receive showers 2x's per week Q (every) Wed on 3-11 shift and Saturday on 7-3 shift..." Medical record review of the Flow Sheet Record for resident #46 revealed, the resident received seven showers between March 1-31, 2013. The resident received four showers between February 1-28, 2013. Interview with resident #46 in the resident's room, on April, 8, 2013, at 4:22 p.m., revealed the resident does not have a choice between bed bath, tub bath, or a shower; and does not choose how many times a week a bath or shower is taken. Continued interview revealed the resident preferred a shower each night.	F 242	F Tag 242 – Self Determination – Right to make choices 1) The Director of Nursing/ Designee will educate and counsel nursing staff members assigned to residents (#46,#115,#47) regarding promoting care and individual self-determination, with an emphasis on encouraging resident choice, asking what the resident's preferred bathing/ shower schedule is in a manner that maintains the resident's self-determination in recognition of his/her individuality. Resident #46 prefers her showers in the evening and shower schedule was changed to honor her choice. (she stated no preference for a specific day). The days remain the same. Resident #115 prefers her showers in the daytime on Tuesdays, Thursdays and Saturdays. This resident's schedule has been adapted to honor her choice. Her showers are now Tuesday, Thursday, Saturday on day shift. Resident#47 Prefers her showers two times a week with no preference for the day but likes it on day shift earlier in the morning. Her shower schedule has been adapted to honor her choice. The days of the week remain the same. Restructure bathing/ shower schedules of resident # 46,#115,#47 to fit needs of resident's choice and reassess at least quarterly by ADON/ Designee. The Assistant Director of Nursing/ Designee to review shower schedule to ensure bathing schedule reflects resident preferences by 5/10/2013. Update the minimum data set (MDS) with individualized shower preferences by MDS/ designee.	May 10, 2013

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F 242	Continued From page 4 Observation of the resident on April 10, 2013, at 7:58 a.m., in the resident's room revealed the resident seated in the wheelchair and was "getting ready to get a bath." Review of the of the Patient Nursing Evaluation for resident #46 dated June 25 and November 25, 2012, revealed a section titled, 'Personal Habits' which had a check box for alcohol and tobacco use and sleep pattern. Review of the evaluation revealed there is no inquiry of the bathing preference (shower or bath) or the frequency of the bathing schedule. Interview with Certified Nursing Assistant (CNA #4) on the Nightingale hallway on April 10, 2013, at 2:00 p.m., revealed "showers are twice per week...they are assigned shower times." Interview with the Director of Nursing (DON) on April 10, 2013, at 2:05 p.m. in the DON's office, revealed the facility does not have a system in place to determine the resident's preference of bathing style or frequency; and confirmed the facility does not have a plan in place to promote the resident's choice in their bathing. Resident #115 was admitted to the facility on September 27, 2011, with Diagnoses including Peripheral Vascular Disease, Neurogenic Bladder and Hypertention. Medical record review of the quarterly MDS dated February 13, 2013, revealed the resident was cognitively intact for daily decision making; required extensive	F 242	The MDS Coordinator/Designee will update the MDS for residents #46, #47, #115 as to individualized preferences of bathing by 5/10/2013. Monitoring of effectiveness of shower/ bathing schedules by interview by social worker (SW) for satisfaction with bathing / shower schedules of residents #46,#115#47 monthly x 3 months reporting need for changes to the assistant director of nursing (ADON) and MDS. The SW will conduct resident interviews to measure resident satisfaction with the adjusted bathing schedules monthly x 3 months and concerns will be directed to the ADON/MDS Coordinator. The interview process will start 5/10/2013. In-service education by SDC/Designee for nursing staff on new shower schedule and honoring our resident preferences will be conducted on 5/9/2013. Staff will be notified by teachable moments given by the ADON/Designee specific to the resident when preferences change. 2) Medical Records to audit 100% of residents for preference of bathing and if cognition is a barrier then discuss with families what that resident was most used to doing in her or his prior level of functioning. Completed by 5/4/2013. Restructure bathing/ shower schedules to fit needs of resident's choice and reassess at least quarterly by ADON/ Designee. The ADON/ Designee will redevelop the bathing schedules to accommodate resident preferences of bathing types and schedules by 5/10/2013. Update MDS with individualized shower preferences by MDS Coordinator/ designee. The MDS Coordinator will ensure resident bathing preferences are accurate in the current MDS by 5/10/2013	

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F 242	Continued From page 5 assistance for personal hygiene; and required physical assistance of one person for bathing. Medical record review of the annual MDS dated November 21, 2012, revealed it was "very important" for this resident to make bathing choices. Medical record review of the Care Plan dated September 27, 2011, revealed the resident was to have two showers a week; one on Wednesday 3-11 shift and one on Saturday 7-3 shift. Interview with resident #115 on April 8, 2013, at 5:02 p.m., revealed the resident did not have choice in bed bath, tub bath or shower; and did not have choice in how many times a week a bath or shower was given. Observation and interview of resident #115 on Wednesday April 10, 2013, at 7:52 a.m., in the resident's room, revealed the resident was expecting to receive a shower later in the day. Interview with DON on April 10, 2013 at 2:33 p.m., in the DON's office, revealed the Care Plan for resident #115 does not reflect the resident's wishes; and confirmed the facility failed to promote the resident's choices in bathing option or frequency. Resident #47 was readmitted to the facility on September 8, 2011, with diagnoses including Parkinson's Disease, History of Falls, Spasm of Muscle, Anxiety, Depressive Psychosis, Abnormal Posture, and Osteoarthrosis.	F 242	and will update preferences as changes occur. Monitoring of effectiveness of shower/ bathing schedules by audit of 3 cognitive residents 5x a week for 3 weeks then 3 x a week for 3 weeks then 1 x a week x 3 weeks and / or until 100% compliance results from audit for receipt of shower/ bath and choices being honored will be conducted by the assistant director of nursing or designee starting on 5/10/2013. In-service training for licensed nursing staff by SDC/ Designee on documenting resident preferences to be completed on admission on every new resident and quarterly on current residents. 4/25/2013. 3) The Staff Development Coordinator will conduct education with the nursing staff on resident self-determination and honoring resident choices.4/25/2013. The Staff Development Coordinator will include information regarding maintaining and/or enhancing patient self-determination and choice in the orientation of all new personnel. 4/25/2013. The Activity Director, or her designee, will interview residents each month at the Resident Council meeting as to whether they feel they have their choices heard and are respected and will report any complaints to the Administrator for follow through by appropriate department head. 5/24/2013. The Social Services Director, or her designee, will conduct 3 individual resident interviews monthly times 3 months to ascertain if the residents choices are being honored and report any complaints to the Administrator for follow through on the grievance log format.	

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F 242	Continued From page 6 Interview with resident #47 on April 8, 2013, at 3:36 p.m., and April 11, 2013, at 3:00 p.m., in the resident's room, revealed the resident preferred a shower daily. Review of the quarterly MDS dated January 23, 2013, revealed the resident was cognitively intact, required extensive assistance with one person physical assistance for bed mobility, transfers, toilet use, and bathing. Review of the March 2013 Flow Sheet Record revealed the resident was to receive a shower two times a week. Review of the Care Plan dated January 30, 2013 revealed the resident needed "...assistance with bathing...Approaches:...shower and shampoo 2 x/week (2 times per week), bedbath on all other days..." Review of the Patient Nursing Evaluation dated August 20, 2012, revealed the resident's personal habit section did not include bathing preferences or frequency. Interview with CNA #2 on April 10, 2013, at 12:40 p.m., in the Ruby Dining Room, revealed the CNA was not aware the resident preferred daily showers. Interview with the DON on April 10, 2013, in the DON's office at 3:15 p.m., confirmed the Patient Nursing Evaluation failed to address the resident's bathing preference and frequency and failed to honor the resident's bathing preference.	F 242	Staff Development Coordinator will include orientation honoring resident choices and the format to assess for some of those choices on admission.4/25/2013. 4) The Director of Nursing, or her designee, will assure through observation, record review, Monitoring of effectiveness of shower/ bathing schedules by audit of 3 cognitive residents 5x a week for 3 weeks then 3 x a week for 3 weeks then 1 x a week x 3 weeks and / or until 100% compliance results from audit by the Assistant Director of Nursing or her designee. The Director of Nursing/ Designee will identify through individual interviews those residents who feel they are not treated in a manner that maintains or enhances their ability to self-determine. The Director of Nursing will take this information to Quality Assurance/Performance Improvement for review by the Interdisciplinary team for evaluation and effectiveness of the plan of correction.. The Administrator is responsible for overall compliance. 5/10/2013. Members of the Quality Assurance /Performance Improvement are: Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development, MDS Coordinator Treatment Nurse, Admissions/ Marketing, Business Office Manager, Rehab Manager Medical Records, Medical Director Social Services, Environmental Services Maintenance Director, Dietitian, Activities Director & Consulting Pharmacist.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445075	A. BUILDING _____ B. WING _____	04/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-MADISON	431 LARKIN SPRING RD MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to develop an individualized care plan with specifics of care for one (# 31) of thirty residents reviewed. The findings included: Resident #31 was admitted to the facility with diagnoses to include Dementia, Meniere's Disease, Depression, Hypothyroidism, and Transient Ischemic Attack.	F 279	F Tag 279 – Develop Comprehensive Care Plans 1) Care plan for Resident # 31 updated to reflect current treatment modalities, location, size, stage, and any nursing precautions by ADON. Wound Progressing well as evidenced by decrease in size. The Director of Nursing/ Designee will in-service and counsel staff members assigned to resident (#31) regarding documentation of resident status/ care changes in care plan and individual treatment modalities, with an emphasis on Pressure Ulcer, nursing precautions, and detailed descriptions of the wound in a manner that reflects accurately the resident's current wound status. 4/25/2013. Weekly notes by At Risk Team (Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Treatment Nurse) to include current wound status, stage, treatment, location, detailed description of current wound and any nursing precautions needed for resident # 31. Any changes noted will be communicated to the nursing staff at the time of change. 5/10/2013. Update MDS with individualized care plan updates by MDS Coordinator/ designee as changes take place based on review of orders in Stand up meeting 5 x's a week. The MDS Coordinator updated the care plan for resident #3 on 4/10/2013 and will continue to update as changes take place or as of review of physician	May 10, 2013

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F 279	Continued From page 8 Medical record review of the Weekly Pressure Ulcer BWAT Report dated February 25 - March 18, 2013, revealed the resident had a stage III pressure ulcer on the left heel. Continued review of the Ulcer Report revealed the wound measured 2 cm (centimeters) x 1 cm x 0.2 cm with undermining <2 (less than) cm and 25 - 50% (percent) of wound covered with necrotic tissue. Medical record review of an Interdisciplinary Note dated April 1, 2013, revealed "...left heel is showing improvement. It does have about 50 - 75% loose yellow slough to the wound bed at this time. We are cleansing with wound cleanser; applying hydrogel; and covering with a dry dressing daily. I am not sure the wound will heal completely with the vascular inefficiency in the leg. There is also a wound to the outer aspect of the left lower extremity which we cleanse with wound cleanser; apply hydrogel to wound bed; packing with gauze strips; and covering with dry dressing..." Medcial record review of the Care Plan revealed skin integrity was addressed but did not specify where the resident's wounds were located; any description of the wounds; specific treatment for the wounds; and nursing precautions to be taken with this resident. Interview with the Director of Nursing (DON) on April 10, 2013, at 3:30 p.m., in the DON's office confirmed the Care Plan had not been revised to reflect the location, stage, specific treatment, and nursing precautions of the Pressure Ulcer to the heel.	F 279	orders. The reviews will take place 5 x a week in stand up meeting. A weekly review of resident care plans regarding wounds will be conducted by Assistant Director of Nursing/ designee based on new order changes. Assistant of Nursing / Designee to assure nursing staff updated daily as to new orders and care plan as changes occur. 4/28/2013. In-service education by Staff Development/Designee was given to the licensed nursing staff on care plan updating based on order changes and wound status changes.4/25/2013. In-service by Staff Development Coordinator/ Designee on proper wound documentation/ description or nursing notes.4/25/2013. 2) Assistant Director of Nursing and Interdisciplinary team will audit all wound care charts for correct and current treatment modalities, nursing precautions if any, staging and current descriptions of wounds/ location. 100% Audit complete by 4/29/2013. Any charts found with non-compliant records were corrected at that time. On admission, all residents with wounds will have a detailed care plan in place describing location, stage, specific treatment and any nursing precautions by Assistant Director of Nursing/Designee. 4/13/2013. The MDS Coordinator will audit 5 wound care plans a week x 3 weeks then 3 wound care plans a week x 3	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 279	Continued From page 8 Medical record review of the Weekly Pressure Ulcer BWAT Report dated February 25 - March 18, 2013, revealed the resident had a stage III pressure ulcer on the left heel. Continued review of the Ulcer Report revealed the wound measured 2 cm (centimeters) x 1 cm x 0.2 cm with undermining <2 (less than) cm and 25 - 50% (percent) of wound covered with necrotic tissue. Medical record review of an Interdisciplinary Note dated April 1, 2013, revealed "...left heel is showing improvement. It does have about 50 - 75% loose yellow slough to the wound bed at this time. We are cleansing with wound cleanser; applying hydrogel; and covering with a dry dressing daily. I am not sure the wound will heal completely with the vascular inefficiency in the leg. There is also a wound to the outer aspect of the left lower extremity which we cleanse with wound cleanser; apply hydrogel to wound bed; packing with gauze strips; and covering with dry dressing..." Medcial record review of the Care Plan revealed skin integrity was addressed but did not specify where the resident's wounds were located; any description of the wounds; specific treatment for the wounds; and nursing precautions to be taken with this resident. Interview with the Director of Nursing (DON) on April 10, 2013, at 3:30 p.m., in the DON's office confirmed the Care Plan had not been revised to reflect the location, stage, specific treatment, and nursing precautions of the Pressure Ulcer to the heel.	F 279	weeks then 1 wound care plan a week x 3 weeks and/ or until 100 % compliance is met, for correct treatment plans, nursing precautions, staging, and current descriptions to individualize and assure current information. Staff Development Coordinator/ Designee will counsel and in-service the staff members identified through this process for care and in-service needs. Update MDS with individualized wound treatment modalities, stages, location and nursing precautions by MDS Coordinator/ designee weekly in At Risk Interdisciplinary team meeting. The MDS Coordinator will update the MDS with individualized treatment modalities, stages, locations and nursing precautions weekly in the Standards of Care Interdisciplinary Team meeting. 4/13/13. 3) The Staff Development Coordinator will conduct an in-service with the nursing staff on resident wound documentation care planning, describing wound and location, staging, treatment modalities and nursing precautions, completed 4/25/2013 The Staff Development Coordinator will include information regarding the process for care plan updates for new orders or changes in orders relating to wounds and the process for new wound documentation in the orientation of all new personnel. 4/25/2013 and ongoing. The residents with wounds will be	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309	Continued From page 9 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to follow physician's orders; failed to notify the physician in a timely manner; and failed to document actions taken for one (#164) of fifty residents reviewed. The findings included: Resident #164 was admitted to the facility on September 11, 2012, following a hospital stay with diagnoses to including Hyponatremia, Nausea and Vomiting, Lung Cancer, Gastroesophageal Reflux Disease, Depression, and previous Myocardial Infarction. Medical record review of Physician's Orders dated September 11, 2012, revealed among the discharge medications for the resident was NaCl (sodium chloride - salt) 1 gram three times daily. Continued review of Physician's Orders dated September 13, 2012, revealed D/C (discontinue) NaCl 1 gram TID (three times daily). Start V8 juice 3 cans daily. Further review of Physician's Orders dated September 14, 2012, (no time), revealed "...Start peripheral IV (intravenous). Infuse NS (normal saline) at 70/hr (milliliters per	F 309	F Tag 309 – Provide Care/ services for Highest Wellbeing 1) Resident # 164 was discharge home from the facility on September 14, 2012. In-service education by Staff Development Coordinator/Designee for nursing staff on policy and procedure for medication ordering and receiving. 4/25/2013 (100% nursing staff) Pharmacy instructed to contact Director of Nursing on private number if ever cannot provide a medication same day to the facility for any reason the day of the order. 4/10/2013 In-service by Staff Development Coordinator/ Designee on proper documentation and follow up when medication is unavailable. 4/25/2013(100% nursing staff) Education also included review of nursing policy regarding resident medication regime and missed medications. 2) Director of Nursing and Nursing Administration team to review each new admission/ readmission and all medication orders Monday through Friday in stand up and Weekend Supervisor on Saturday and Sunday. 5/10/2013. If any non-compliance with medication administration, MD notified and immediate correction is made. Director of Nursing/ Designee to audit residents with new orders or changes in orders 5 x a week x 3 weeks then 3 x a week x 3 weeks and then 1 x a week until 100% compliance is met to verify	May 10, 2013

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F 309	Continued From page 10 hours) for 2 liters. Na level after 1 liter of NS..." Continued review of Physician's Orders dated September 14, 2012, (no time), revealed "...Stat Na level. NaCl tabs I po (orally) TID..." Further review of Physician's Orders dated September 14, 2012, (no time), revealed "...Continue with V8 juice 1 can QID (four times daily) until NaCl tabs arrive. Call stat Na level. Call ANP (Advanced Nurse Practitioner) if NaCl tabs do not arrive today..." Continued review of Physician's Orders dated September 14, 2012, (no time), revealed "...D/C home, Na 123" (normal 135 - 145). Medical record review of the Medication Administration Record (MAR) revealed the NaCl 1 gram TID was hand written on the admission MAR. Continued review of the MAR for September 2012 revealed the Nurse's initials were circled (to denote medication was held) on September 12, 2012, at 8:00 a.m., 2:00 p.m., and 9:00 p.m. Review of the back side of the MAR revealed a Nurse's Note stating the 9:00 p.m. dose of NaCl was held because the resident was sleeping. Further review of the September 2012 MAR revealed the NaCl was documented as being administered on September 13, 2012, at 8:00 a.m., and 2:00 p.m. with a circle around the Nurse's initials for the 9:00 p.m. dose and a note on the back of the MAR stating the medication was held because the resident was sleeping. Continued review of the September 2012 MAR revealed the NaCl 1 gram TID was discontinued on September 13, 2012 and V8 juice 3 cans per day was added but there was no documentation the juice was ever given. Medical record review of a Nursing Note dated September 12, 2012 at 12:20 a.m., revealed	F 309	medications are in cart and documentation is complete. 4/25/2013. In-service education by Staff Development Coordinator/Designee for licensed nursing staff on policy and procedure for medication ordering and receiving and notification of the MD or NP and to get further orders. 4/25/2013. In-service by Staff Development Coordinator/ Designee given to all licensed nursing staff on proper documentation and follow up when medication is unavailable and call Director of Nursing for help with any pharmacy issues. .4/25/2013. 3) The Staff Development Coordinator will conduct an in-service with the nursing staff on policy and procedure for medication ordering and receiving and in that to call the MD or NP and get further orders. In-service by Staff Development Coordinator/ Designee on proper documentation and follow up when medication is unavailable and call Director of Nursing for help with any pharmacy issues. The Staff Development Coordinator will include information regarding the process for timely acquiring medications from pharmacy, acquiring medications from the e kit as appropriate, or via back up pharmacy. Documentation of medications as given or held and documentation of MD/NP called and orders received concerning medications when not available in the orientation of all new personnel. 4/25/2013 and ongoing.	

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F 309	Continued From page 11 "...called ...(named Physician) related to medication did come from Pharmacy except Dilaudid x10. Give as soon as they arrive from backup pharmacy. Do not hold meds. Pharmacy is out of Democlocycline 150 mg will bring in tomorrow..." Continued review of Nursing Notes revealed no documentation the Physician was notified the NaCl was not delivered by Pharmacy. Further review of a Nursing Note dated September 14, 2012, with no time, revealed "...ANP (Advanced Nurse Practitioner) called D/T (due to) critical NaCl at 119. Infuse 2 L (liters) NS @ 70/hr. Na level after first liter..." Medical record review of an entry by the ANP dated September 14, 2012, with no time, revealed "...NaCl 1 gram po TID ordered from hospital. I was notified at 1900 (7:00 p.m.) September 13, 2012, that NaCl tabs have not been given since admission. Physician ordered V8 juice 1 can TID. I was notified today (9/14/12) that V8 juice had not been given and Na level was 119. Order for NS @ 70/hr x 2L. When I arrived at facility Nurse unable to obtain access (unable to start IV)..." Medical record review revealed the resident was discharged home on September 14, 2012, with orders to follow up with personal Physician. Review of facility policy, Medication Ordering and Receiving, revealed "...if the medication is not available in the emergency kit or through the provider pharmacy, contact the back-up pharmacy for the medication. If the medication continues to be unavailable, contact the physician for further instructions..."	F 309	The Director of Nursing, or her designee, will conduct record reviews and review audits (residents with new orders 5 x a week x 3 weeks then 3 x a week x 3 weeks and then 1 x a week until 100% compliance is met to verify medications are in cart and documentation is complete). for residents with new orders to verify medications are in cart and documentation is complete. Findings to be reported to Administrator for review. SDC will use this is coordination with Director of Nursing to identify reeducation needs or counseling needs for staff. 4/25/2013. 4) The Director of Nursing, or her designee, will assure through observation, record review and order review/audit reviews that residents medication has been acquired per orders or alternate orders have been obtained and take information to Quality Assurance/Performance Improvement for review by the Interdisciplinary team for evaluation and effectiveness of the plan of correction. Members of the Quality Assurance /Performance Improvement are: Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development, MDS Coordinator Treatment Nurse, Admissions/ Marketing, Business Office Manager, Rehab Manager Medical Records, Medical Director Social Services, Environmental Services Maintenance Director, Dietitian, Activities Director & Consulting Pharmacist.	

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F 309	Continued From page 12 Interview with the Director of Nursing on April 10, 2013, at 8:30 a.m., in the Director's office, confirmed the medication was not given as ordered, the juice was not given as ordered, and the staff had failed to notify the Physician. C/O # 30757	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide a toileting program for incontinence for one resident (#118) of fifty residents reviewed. The findings included: Resident #118 was admitted to the facility on November 21, 2012, with diagnoses including Cerebral Vascular Accident, Blindness in one eye, Cutaneous Candidiasis, Intracerebral Hemorrhage, Debility, Diabetes Mellitus II, Urinary Tract Infection, Hypertension, and Hemiplegia.	F 315	F Tag 315 – No Catheter, Prevent UTI, Restore Bladder 1) Resident #118 was discharged home on 1/17/2013. The Director of Nursing/ Designee will in-service nursing staff members assigned to Residents needing bowel and bladder evaluations and or toileting programs, regarding promoting care, with an emphasis on making the resident less incontinent or encouraging regaining as much normal bladder and bowel function as possible in a manner that maintains the resident's dignity in recognition of his/her individuality. 4//25/2013. The facility does offer a bowel and bladder program at this time. Documentation forms in place to show program (toileting/ incontinence) resident placed on (after 3 day bowel and bladder evaluation completed) and compliance with program. Reevaluation as needed and quarterly for changes in needs by ADON. Already in place and ongoing. 4/8/13. In-service training for Licensed Nursing staff by SDC/ Designee on 3 day bowel and bladder evaluation sheets and toileting program and documentation 4/25/2013 2) All current residents on an Incontinence/ toileting program will be reviewed by the Assistant Director of Nursing to ensure residents are receiving care as indicated. 4/8/2013. Assistant Director of nursing will	May 10, 2013

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F 315	Continued From page 13 Medical record review of a Three Day Voiding Pattern Assessment Form dated November 2012 revealed the resident was always incontinent. Further review revealed "Incontinence program to be initiated." Medical record review of the Care Plan revealed a program for incontinence had been placed on an incontinence program. Interview with the Director of Nursing (DON) on April 10, 2013, at 1:40 p.m., confirmed the facility does not have a Bowel & Bladder program in place currently, but does have toileting and incontinence care programs. Further interview revealed the form now being used for the toileting program was not in place during this resident's admission.	F 315	monitor weekly new 3 day completed bowel and bladder assessments on new or readmits and quarterly on all other residents and refer to toileting program as needed. Copies of 3 day bowel and bladder evaluations will be brought to weekly Standards of care meeting to be evaluated by the interdisciplinary team. 4/22/13. The Director of Nursing/ Designee will identify all residents on toileting program by auditing care plan and toileting program documentation 5 x a week x 3 weeks then 3 x a week x 3 weeks then 1 x a week x 3 weeks until results from audit show 100% compliance met through toileting program documentation. 4/13/2013. The Assistant Director of Nursing/ Designee will counsel and in-service the staff members identified through this ongoing process. 3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not occur, and The Assistant Director of Nursing will monthly set up and change over all documentation forms for toileting / incontinence to ensure accuracy and staff understanding. 5/1/2013. The Staff Development Coordinator will conduct an in-service with the nursing staff regarding 3 day bowel and bladder evaluation sheets and toileting program and documentation. 4/25/2013 The Staff Development Coordinator	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to serve pureed vegetables at a pudding or mashed potato consistency per policy for one meal on two of three tray lines. The findings included:	F 364		

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	445075	A. BUILDING _____ B. WING _____	04/10/2013

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F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to serve pureed vegetables at a pudding or mashed potato consistency per policy for one meal on two of three tray lines. The findings included:	F 364	4) The Director of Nursing or her designee, will assure through observation, record review and audit review that toileting programs are being documented appropriately and offered / individualized and taken to Quality Assurance/ Performance Improvement for review by the Interdisciplinary team for evaluation and effectiveness of the plan of correction.. The Administrator is responsible for overall compliance. Members of the Quality Assurance /Performance Improvement are: Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development, MDS Coordinator Treatment Nurse, Admissions/ Marketing, Business Office Manager, Rehab Manager Medical Records, Medical Director Social Services, Environmental Services	

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F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to serve pureed vegetables at a pudding or mashed potato consistency per policy for one meal on two of three tray lines. The findings included:	F 364		

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F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to serve pureed vegetables at a pudding or mashed potato consistency per policy for one meal on two of three tray lines. The findings included:	F 364	F Tag 364 Nutritive Value/Appearance, palatable/preferable temperature 1) The dietary manager will educate dietary staff on the correct method of preparation for mechanically altered vegetables (specifically pureed) to ensure that all purred vegetables are prepared and presented to the residents in accordance with the prescribed consistency defined in the policy and procedures. This education will focus on the end product being presented on the plate as a soft mound, mashed potato consistency, without the presence of excess fluid. This education will be conducted on 5/6/2013 and 5/7/2013. 2) Dietary Manager will review all resident diets that include pureed texture following education sessions to ensure texture is consistent with policy. 3) The Administrator or designee will monitor the prepared mechanically altered (pureed) vegetable items on the tray line during the temperature capture procedure 5 times per week for 4 weeks to ensure that the appropriate preparation methods have been used and resulted in the appropriate texture (soft mound, mashed potato consistency) for service to the residents.	May 10, 2013

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F 364	Continued From page 14 Observation of the tray lines in process on April 10, 2013, at 12:06 p.m., in the dietary department and at 12:44 p.m., in the Ruby Dining Room, revealed the pureed spinach covered the surface of the plate provided to the resident. Review of facility policy, Food Preparation and Presentation, effective November 18, 2005, revealed "...4. Puree foods should be of the consistency of pudding or mashed potatoes and served on a regular plate..." Interview with Dietary Staff #2 serving the food on April 10, 2013, at 12:44 p.m., in the Ruby Dining Room, confirmed the pureed spinach was "runny." Interview with the Registered Dietitian in the Diamond Dining Room, on April 11, 2013, at 7:45 a.m., confirmed pureed vegetables should be a soft mound on the plate and not cover the surface of the plate.	F 364	When observed to be correct, this will be logged alongside the temperature recording. If the product is found to be too loose or runny, it will be removed from the tray line and either modified appropriately or re-prepared to meet texture guidelines. Reeducation and/or disciplinary actions for non-compliance will be conducted by dietary manager as indicated. 4) The Administrator will meet with the dietary manager weekly for 4 weeks to review the texture logs and menus to ensure that all mechanically altered (pureed) vegetable items are being prepared and served according to policy and are being recorded accurately. This will also be brought to the monthly quality assurance/ PI meetings for 90 days to review with the facility IDT team beginning with the May, 2013 meeting. Members of the Quality Assurance /Performance Improvement are: Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development, MDS Coordinator Treatment Nurse, Admissions/ Marketing, Business Office Manager, Rehab Manager Medical Records, Medical Director Social Services, Environmental Services Maintenance Director, Dietitian, Activities Director & Consulting Pharmacist.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371		

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F 371	Continued From page 15 by: Based on observation, facility policy review, and interview, the dietary employees failed to restrain their hair during the meal service on two of three tray lines of two meals observed. The findings included: Observation on April 8, 2013, at 12:06 p.m., of the dietary department tray line in process, revealed Dietary Staff #1's bangs were not restrained under the hair covering. Observation on April 9, 2013, at 7:50 a.m., of the Diamond Dining Room tray line in process, revealed Dietary Staff #2's bangs were not restrained under the hair covering. Review of facility policy, Principles of Safe Food Handling, effective April 28, 2011, revealed "...1.c. Restrain hair appropriately. Hair restraints such as hats, hair covering or nets are worn to effectively keep hair from contacting food and keep food handlers from touching their hair..." Interview with the Nutrition Services Manager on April 8, 2013, at 12:15 p.m., at the dietary department tray line in process, confirmed the hair was to be totally under the hair covering.	F 371	F Tag 371 Food Procure, store/prepare/serve - sanitary 1) All dietary staff will be in-serviced on the appropriate use of hair nets to follow policy and ensure that all hair is effectively restrained underneath the hair net at all times. This education was completed by the dietary manager on 4/30/2013. 2) The Administrator, dietary manager or designee will evaluate the use of hair nets during food production immediately following education. All dietary employees will receive education and monitoring to ensure compliance. 3) The Administrator or designee will perform randomly timed uniform checks on all dietary staff present five times per week for four weeks, then three times per week for four weeks, then once per week for four weeks. Any deficient practice found during inspection will be corrected immediately and additional education provided. 4) Beginning on 5/10/2013, the Administrator will discuss the uniform audits with the dietary manager weekly. Employees will be re-educated as necessary by the dietary manager and if needed, facility disciplinary procedures for non-compliance will be followed. The results of these inspections will also be brought by the Administrator before the quality assurance/PI team monthly for 90 days.	May 10, 2013
F 372 SS=E	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by:	F 372		

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F 372	Continued From page 16 Based on observation and interview, the facility failed to maintain the grounds around the exterior dumpsters in a sanitary manner for one of two dumpsters. The findings included: Observation and interview with the Nutrition Services Manager, on April 8, 2013, at approximately 12:20 p.m., of the exterior facility dumpster, confirmed the grounds around one of two dumpsters had three plastic gloves and various paper debris items present.	F 372	F Tag 372 Dispose of garbage and refuse properly 1) The ground area around the dumpsters was immediately cleaned by the dietary manager upon observation of debris. All dietary and housekeeping staff will be in-serviced and educated on the regulations and importance of proper disposal of trash for the facility. This in service will be given by the plant operations manager on 5/6/ and 5/7 2013. 2) All trash disposal areas are included in this plan and will be monitored by the plant operations manager. 3) Educations for all employees will focus on the necessity of ensuring all refuse and garbage is placed inside of the containers (dumpsters) and no loose trash is present on the ground around the dumpsters at any time. Plant operations manager is providing this education on 5/6/13/and 5/7/2013. Monitoring of employee practice following education will begin immediately following education sessions. 4) The plant operations manager or designee will monitor the ground area around the dumpsters five times per week for four weeks, then three times per week for four weeks, then once per week for four weeks and then periodically. Results of this monitoring will be discussed weekly with the Administrator and monthly with the quality assurance team during quality	May 10, 2013
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441		

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F 441	Continued From page 17 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide sanitary handling of food. The findings included: Observation on April 8, 2013, at 12:55 p.m., in the Ruby Room dining area revealed Certified Nursing Assistant (CNA) #2 feeding a resident. continued observation revealed CNA #2 took a spoon of food and blew on it before feeding it to the resident. Interview with CNA #2 on April 8, 2013, at 1:08 p.m., confirmed CNA #2 "did it without thinking and then realized what had happened."	F 441	infection control and safe food handling in the orientation of all new personnel. 4/25/2013. Direct observation by Assistant Director of Nursing or Designee in dining room for infection control, proper way to cool off food and safe food handling, , 5 times a week x 3 weeks then 3 x a week x 3 weeks and then 1 x a week x 3 weeks and/ or until 100% compliance is met. 4/13/2013 The Administrator will be notified of the outcome weekly and Staff Development Coordinator will be given information for follow up with staff for education/ reeducation as needed. 4) The Director of Nursing, or her designee, will assure through observation and audits, that residents are being assisted with meals following infection control procedures and safe food handling, and take to Quality Assurance/Performance Improvement for review by the Interdisciplinary team for evaluation and effectiveness of the plan of correction. Members of the Quality Assurance Performance Improvement are: Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development, MDS Coordinator, Treatment Nurse, Admissions/ Marketing, Business Office Manager, Rehab Manager, Medical Records, Medical Director Social Services, Environmental Services, Maintenance Director, Dietitian, Activities Director, Consulting Pharmacist.	
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional	F 514		

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F 514	Continued From page 18 standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure medical records were complete and accurate for seven (#18, #59, #70, #108, #127, #141, #66) of thirty resident closed records reviewed. The findings included: Resident #18 was admitted to the facility on December 1, 2012, and discharged on December 31, 2012. Medical record review of the Interdisciplinary Discharge Summary revealed the section on Final Summary of the Resident's Status was not completed. Continued review of the Discharge Summary revealed no assessment was documented by Social Services, Nursing, Activities, and Therapy. Further review of the Discharge Summary revealed the Dietary section was documented on April 8, 2013. Resident #59 was admitted to the facility on January 18, 2013, and discharged on February 20, 2013. Medical record review of the Interdisciplinary Discharge Summary revealed the	F 514	F Tag 514 – Resident Records-Complete/Accurate/Accessible 1) What corrective action will be accomplished for those residents found to be affected by the deficient practice. Resident #18 discharge summary completed by 5/4/2013 . By ADON, SW, Rehab, Activities Resident#59Discharge summary completed by5/ 4/2013. By ADON, SW, Rehab, Activites Resident#70Discharge Summary completed by 5/4/2013. By ADON, SW, Rehab, Activites Resident#108 Discharge Summary completed by 5/4/2013 By ADON(finished), SW, Rehab, Activites Resident#127 Discharge Summary completed by 5/4/2013 By ADON; SW, Rehab, Activites Resident#141 Discharge Summary completed by 5/4/2013 By ADON, SW, Rehab, Activites Resident#66 Discharge Summary completed by 5/4/2013. ADON corrected Discharge Summary to reflect correct absence of vitals at time of reason of discharge. 100% audit of all Discharge charts was conducted by Medical Records Director, no additional deficient Discharge summaries were found. 2) The Director of Nursing/ Designee will identify through record review after 72 of discharge from facility that discharge summary is completed by nursing. The	May 10, 2013

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445075	A. BUILDING _____ B. WING _____	04/10/2013

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F 514	Continued From page 19 section on Final Summary of the Resident's Status was not completed. Continued review of the Discharge Summary revealed no documentation by Social Services, Nursing, Activities, and Therapy. Further review of the Discharge Summary revealed the dietary section was documented on April 8, 2013. Resident #70 was admitted to the facility on October 25, 2012. Medical record review of the Interdisciplinary Discharge Summary revealed no date of discharge, reason for admission, progress, and reason for discharge were documented. Continued review of the Discharge Summary revealed the section on Final Summary of Resident's Status was not completed. Further review of the Discharge Summary revealed no documentation by Social Services, Nursing, Activities, and Therapy. Continued review of the Discharge Summary revealed the dietary section was documented on April 8, 2013. Resident #108 was admitted to the facility on January 9, 2013. Medical record review of the Interdisciplinary Discharge Summary revealed no date of discharge, no progress, or no reason for discharge were documented. Continued review of the Discharge Summary revealed the section on Final Summary of the Resident's Status was not completed by Social Services; Nursing section was incomplete and dated April 8, 2013; Dietary section was documented on April 8, 2013. Further review of the Discharge summary revealed there was no documentation from Activities and Therapy. Resident #127 was admitted to the facility on October 22, 2012, and discharged on November	F 514	Medical records director will bring the chart to stand up after the 72 hour period is over and the other disciplines will sign their portion. Medical records director will audit all discharge charts weekly for completeness of discharge summaries and turn in to the Administrator 5 times a week x3 weeks then 3times a week x 3 weeks then 1 time a week x 3 weeks and until 100% compliance results from auditing. The Director of Nursing and Administrator will counsel and in-service the staff members identified through this process. 5/10/2013. 3) The Staff Development Coordinator will conduct an in-service with the nursing staff and with the Interdisciplinary team on timely filing out of discharge summaries when residents are discharged from facility. The Staff Development Coordinator will include information regarding completing them within 72 hours of discharge in the orientation of all new personnel. The Medical Records Director will bring the charts due for discharge summaries to standup for completion and report any incompletion to the Administrator for follow through. Medical records director will audit all discharge charts5 times a week x3 weeks then 3times a week x 3 weeks then 1 time a week x 3 weeks and until 100% compliance results from auditing for completeness of discharge summaries and turn in to the Administrator for review. 4/25/2013 and ongoing. Medical Records Director was included in this in-service.	

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F 514	Continued From page 20 11, 2012. Review of the Interdisciplinary Discharge Summary revealed the section on Final Summary of the Resident's Status was not completed. Continued review of the Discharge Summary revealed no documentation by Social Services, Nursing, Activities, and Therapy. Further review of the Discharge Summary revealed the dietary section was documented on April 8, 2013. Resident #141 was admitted to the facility on December 4, 2012 and discharged on December 21, 2012. Medical record review of the Interdisciplinary Discharge Summary revealed the section on Final Summary of the Resident's Status was not completed. Continued review of the Discharge Summary revealed no documentation by Social Services, Nursing, Activities, and Therapy. Further review of the Discharge Summary revealed the dietary section was documented on April 8, 2013. Interview with the Director of Nursing on April 10, 2013, at 9:00 a.m., in the Director's office, confirmed the discharge summary was incomplete for these residents. Resident #66 was admitted to the facility on January 16, 2013, with the diagnoses of Cerebral Vascular Accident, Right Heel Ulcer, Diabetes Mellitus II, Hypertension, Neuropathy, and Dementia. Medical record review of the Interdisciplinary Discharge Summary dated February 10, 2013, revealed "...reason for discharge...expired...vital signs at time of discharge...temp 97, pulse 74, resp 26, B/P 112/60..."	F 514	4) Medical records director will audit all discharge charts 5 times a week x3 weeks then 3times a week x 3 weeks then 1 time a week x 3 weeks and until 100% compliance results from auditing for completeness of discharge summaries and turn in to the Administrator weekly to take to Quality Assurance/Performance Improvement Meeting for review by the Interdisciplinary team for evaluation and effectiveness of the plan of correction. Members of the Quality Assurance /Performance Improvement are: Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development, MDS Coordinator Treatment Nurse, Admissions/ Marketing, Business Office Manager, Rehab Manager Medical Records, Medical Director Social Services, Environmental Services Maintenance Director, Dietitian Activities Director, Consulting Pharmacist.	

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F 514	Continued From page 21 Interview with the Director of Nursing (DON) on April 10, 2013, at 2:30 p.m., in the DON's office, confirmed the resident should not have vital signs if had expired.	F 514		